questions in each subject be set with a view of bringing out the esxperience he ought to have acquired. If he fail where he ought to be strong, then reject him without mercy, but give him the chance the law intended, and professional courtesy demands.

Our present standard must be raised rather than lowered, but if we are to succeed in the salvation of an excellent law we must give no points to the enemy.

COOPER COLLEGE SCIENCE CLUB.

Discussion:

Doctor Wm. Fitch Cheney: It is only a few years since we were taught that ulcer of the duodenum was very unusual as compared with ulcer of the stomach. And it is only comparatively recently that the Mayos have determined that ulcer of the duodenum is as frequent as ulcer of the stomach and according to their statistics a little more so. But from the standpoint of the clinician it does not seem to me that it makes very much difference as to whether the ulcer it situated one or the other side of the pylorus. Many are situated across the pylorus and defy the powers of the physician to decide whether the ulcer is on one or the other side. After all if we consider the matter as belonging all to the same group of cases it does not make much difference. At the utmost, a space of three or four inches is involved; and for a man to make up his mind whether the ulcer is in the first, second or third inch of that space is impossible. After he has seen his cases operated upon a few times he mistrusts his conclusions. The diagnosis of the ulcer in the exact situation is a very difficult matter and does not make very much difference as to which side of the line the ulcer lies. The points which Doctor Levison has made are all very good. I have no fault to find with his methods of diagnosis and nothing to say regarding his methods of treatment. In chronic ulcer nothing can be expected from the medical treatment, and where there is a history of the condition going on for years, changes occurring in the vicinity of the ulcer, stenosis or perigastric, or peri duodenal adhesions, or attachment to the stomach or bowel, it is incredible that any medical treatment should be expected to cure and mechanical measures are the only cures. The question of differential diagnosis as between ulcer and conditions of the gallbladder has been brought up by Doctor Levison and this always causes a great deal of difficulty in diagnosis. The upper right quadrant of the abdomen is one of the most difficult regions for diagnosis. In gallbladder troubles or pancreatic conditions it takes time and work to reach conclusions by which we are able to make our diagnosis. Gallbladder cases differ in their history with regard to the occurrence of the attacks, and secretions of stomach and absence of blood from the bowels. We do not expect to find occult blood in the feces in gallbladder disease but peptic ulcer or in duodenal ulcer we do expect to find this; furthermore we find a comparatively clear interval of perfect health between attacks whereas, in the interval between the attacks of ulcer there is a great deal of dyspepsia; the character of the pain is usually different in the two. There is a very much greater intensity of the attack in the passage of gallstones, there is an absence of stomach symptoms whereas in ulcer there is the characteristic gastrology. After all this has been gone over I believe that again and again we find ourselves unable to decide. We may have a firm conclusion and yet we find ourselves deceived when the abdomen is opened. The only solution we have in the matter is that any one of these serious conditions call for surgery and the patient does not suffer by being submitted to operation. In the early cases of ulcer, whether in the stomach or duodenum, cure can be effected by medical means, but I think it very important to realize that after the case has gone on for years with recurring attacks it is absolute folly to expect permanent cure by medical means. We can improve these cases but sooner or later recurrence occurs and the confidence of the patient in the medical means suffers very materially. It is far wiser to urge the patient to submit to operation.

Doctor Emile Schmoll: As for our abdominal conditions we are indebted to the surgeon for the recognition of duodenal ulcer about which we knew very little before the time of abdominal operations. I think, however, that at present there is a tendency to exaggerate the frequency of duodenal ulcer which is often diagnosed and the ulceration is really situated at the minor curvature. Such cases are primarily gastric ulcerations and involve the duodenum afterwards. The differential diagnosis between duodenal ulceration and gastric ulcer is usually based on the following symptoms: bleeding by rectum and the occurrence of pain a long time after meals. I would like to say that exclusive bleeding by rectum is not characteristic of duodenal ulceration, as I have seen in gastric ulceration. I remember one case in which, as four or five large hemorrhages occurred through the intestines, the diagnosis was made of duodenal ulcer; there was, however, one point which attracted my attention and which made me doubtful; I finally decided to diagnose gastric ulcer in preference to duodenal based on the fact that the pain depended upon the position of the patient, occurring only when he laid on his left side. This is a most valuable sign in gastric ulceration. If gastric pain changes on changes of position I never hesitate to diagnose gastric ulcer; if it is dependent upon food and does not change on change of position I usually diagnose duodenal ulcer. In this case the patient could not lie on the right side, he was free from pain as soon as he turned over on the left side. My diagnosis of ulceration of the minor curvature near the pylorus was verified at operation. So far as treatment is concerned I do not think that we are justified in sending every case to operation; we know too little of the clinical history of duodenal ulceration, we have not known the condition long enough to observe the ultimate outcome. In cases of gastric and duodenal ulcer the treatment usually does not extend over a sufficient length of time; it is my conviction that treatment is not complete unless the patient has been kept in bed for at least six weeks on a soft diet. There are especially two complications of duodenal ulcer which are often put to the physician before the question of immediate operation: bleeding, one of the most dangerous complications,—and still I think it wiser to wait as a general rule until the hemorrhage has stopped before operation. First of all we are not sure to find the bleeding point which I have seen looked for in vain in a number of operations. I remember especially one case which a number of gentlemen present have seen where hemorrhages have persisted over a period of ten years and in which at operation no trace of the bleeding point could be seen. I think, however, that if an ulceration keeps on bleeding notwithstanding rational treatment, operation should be performed. The second complication is perforation, which of course, demands immediate operation. Perforation is a complication which, of course, demands immediate operation. I have seen in the last year two perforations of duodenal ulcer which were characteristic. In one the perforation had led to a pouch which was localized between the stomach and the liver. A case occurred recently at the City and County service of Lane Hospital. A man had come in with a history of long-standing dyspepsia which had grown worse in the last two or three years, but we got no his-

tory of sudden sharp pain or shock; he had simply grown worse in the last forty-eight hours. On examination we found rigidity of the muscles over the epigastrium, and Dr. Rixford and I were not quite sure whether it was a case of acute pancreatitis or whether there was perforation of a duodenal ulcer. On operation we found perforation of the duodenum with extra-sation of gastric contents all over the abdomen. This patient recovered.

Doctor J. Wilson Shiels: I find that a great number of men allow these cases to continue so long that the surgeons can do no good at all. If ulcer is diagnosed it would be wise to call in a surgical consultant, just as one should be in the habit of keeping in touch with a surgeon during a patient's third stage in typhoid. The physician should not wait until the stomach has lost its function before consulting the surgeon.

Doctor Chas. G. Levison: I am very glad to hear Doctor Cheney express himself as he has done concerning this subject, and I think it shows the result of his intimate association with surgeons. Medical men are apt to treat these cases as intestinal dyspepsia, neurasthenia, etc., which surgeons as the Mayos and Moynihan have shown to be organic. The surgeons have been a long time educating the medical man to favor operations upon the appendix, and now a physician is more apt to advise operation than the surgeon; frequently at consultation, operation is more strongly advised by the physician. Doctor Schmoll has referred to the acute ulcers, but these conditions are not those which have been discussed this evening. It is well known that many acute gastric and duodenal ulcers heal under treatment or even spontaneously. When these cases recur after a period of rest of six months or a year, they are not apt to disappear entirely. A marked characteristic of a chronic duodenal ulcer is its periodicity and the interval during which time the patient is free from symptoms. I have now three patients who undoubtedly have duodenal ulcer. One is getting ready for operation after several years of observation; during this period the patient has never been free from symptoms. This is the class of cases that does not get well under diet. They do not often pass into the hands of the surgeon and eventually develop carcinoma, where naturally the prognosis is exceedingly grave even when the patient is operated upon. There is only one thing that can influence the prognosis in carcinoma, and that is to operate before metaplasia has taken place, for it has been shown that between 50% and 60% of gastric carcinomata give a history of gastric ulcer. On the other hand, duodenal ulcers are not prone to develop into carcinoma, but are more frequently complicated with hemorrhage and perforation. The opinion is general now that no operations should be performed upon the stomach where an indurated base to the ulcer is not present, and that an ulcer for operation should be visible to an onlooker six or eight feet from the operating table. There is no reason for performing a gastro-enterostomy unless obstructive signs are present, and if it is done where no stenosis is demontrable, nothing is accomplished, for the anatomic opening will close and the pylorus will functionate as before.

DEMONSTRATION OF A SPLEEN.*

By WM. FLETCHER McNUTT, M. D.

Mr. M., age 46, miner by occupation, resident of Nome, Alaska, for the last seven years. He complained of a large tumor in the splenic region which he had noticed for a year and a half, frequent attacks of indigestion and vomiting, and great dyspnea. History negative, never had malaria, syphilis, typhoid, nor had he been a resident of the tropics. Six years ago he had a fall and sustained a severe blow in the splenic region. Has been an alcoholic all his adult life. Examination showed an enlarged spleen filling the left side of abdomen and extending to crest of ileum. Heart action irregular, apex displaced upward and to the left, lung normal, kidneys and liver negative, blood red cells slightly diminished, and no leucocytosis. Operation, abdomen opened over spleen, which was found to be firmly adherent over the entire surface. Breaking up these adhesions caused great hemorrhage and profound shock, which continued throughout the operation. Adhesions broken up, spleen removed, and hemorrhage controlled by packing. Patient was returned to bed in condition of shock. Lived six hours. Weight of the spleen when removed was twelve and a half pounds.

* Read before the regular meeting of the San Francisco County Medical Society, April 13, 1909.

Discussion.

Doctor J. W. Shiels: It may be of some interest for me to mention a case of splenectomy which ended fatally within twelve hours after operation. This particular case came to my office, telling me that his wife had told him that he was sick, that his wife had told him that he perspired, that his wife told him that he was breathless, and that he had dyspnea. He had found nothing to account for all these symptoms and he went on working, but because of continued urging of the wife he came to the city and here discovered that he was suffering from bleeding hemorrhoids. Upon examination we found the blood pressure somewhat high, a very large spleen, much larger after operation than even the physical signs indicated. Upon palpation the spleen was extremely free and moving with respiration quite easily, and did not seem to distend very low, the border being above the umbilicus. But upon operation we found the spleen to be enormous, as though most of its growth had been thrown up rather than descending, although from any movement during operation it was evident there were an enormous number of adhesions. The cause of death was probably due to collapse and hemorrhage. Returning to the clinical history, the spleen was extremely large, did not show any cachexia, the liver was very large, so large indeed that we hesitated in giving a diagnosis of Banti's disease; the blood count showed large lymphocytes, but a very small blood count of leucopenia. The man progressively got worse, the heart was in good shape, he showed great discomfort from the large spleen, suffered from all forms of movement severe acute pain. He was under large doses of arsenic. We put him through a long course of mercurial treatment without any result; we did all we could to get him into a better state of health. At the end of all this we confronted him with the alternative, operation. We removed one or two glands to ascertain whether he had Hodgkin's disease; having excluded that and having excluded syphilis, and having no reason to believe the man in any sense tubercular, we gave him the alternative of operation. The operation was performed, but he lived only a few hours.

Doctor H. D'Arcy Power: In the matter of diagnosis it is interesting to note that the position of the spleen varies quite frequently in these cases. I have seen two or three cases within the last two or three years; one was an enormous spleen. There was a typical splenic notch on the right side, although the spleen itself was far down toward the pelvic cavity; that case was not difficult to diagnose. A few months ago I saw a case with Doctor Morton which was interesting and to some extent puzzling. Here the whole cavity was filled with a tumor that had steadily grown for seven or eight months. The diagnosis had been made by someone of sarcoma of the kidney. The splenic notch was palpable on the right side across the mid line and down in the pelvic region. I do not know the result of the exam-